7 AAC 105.230(d)(7) 72 hour contemporaneous documentation FAQ

1. **Please clarify the 72 hour requirement for documentation of services, is this a straight 72 hours or is its 72 business hours.**

   A: The 72 hour requirement applies to the initial documentation of services. The regulation states 72 hours from the *end date of service*. This is a straight 72 hours from the *end of date of service*. An example is the date of service is June 15, 2018, the 72 hour clock starts at 12:00 am June 16, 2018 and is to be documented by 11:59 pm June 18, 2018.

2. **What about weekends and holidays?**

   A: The 72 hour requirement does not allow an extension for weekends and holidays.

3. **What about corrections to errors? As you know, most providers have a process of reviewing timesheets and other documentation for errors, then sending the documents back to the employee for corrections.**

   A: It is anticipated that a providers' quality assurance process may identify errors outside of the 72 hour requirement.

   If provider needs to amend or correct a clinical record entry then the following recordkeeping principles apply:

   - Clearly identify all original content (do not delete).
   - Clearly and permanently identify any amendments, correction, or addenda.
   - Clearly indicate the date and author of any amendments, corrections or addenda.

   Paper Record
   A single line strike through should be used so the original content is still readable. The person amending or correcting the clinical record must sign and date the revision, amendment or addenda (change).

   Electronic Health Record
   The change must be distinctly identified and there should also be a way to provide a reliable means to clearly identify the original content and the modified content. The person amending or correcting the clinical record and the date of the change must also be documented.

   Audit Phase
   Once a claim has been selected for audit, the documentation associated with the claim would be evaluated prior to the date the claim was selected.

3. **Some services use a weekly timesheet that records individual dates of service, shifts worked (in/out times), tasks completed, and case notes/response to care comments; further, while these items are generally captured at the conclusion of each shift, the timesheet itself is not signed and dated by a caregiver until the week of service has concluded.**

A: For services that are typically documented through the use of a timesheet, a weekly signature is acceptable. Time in and time out, services provided and clinical notes must be maintained in accordance 7 AAC 105.230.

4. **Assessments are performed on multiple days and may include a treatment team, when does the 72 hour clock start?**

   A: Some services are provided over a span of dates, including assessments, the date of service is the date the service concluded. The 72 hour clock will start at the end date of service.

5. **What if we start the assessment and we conduct an initial interview the client on day one, complete all our collateral contacts over days two and three, and then the client never returns for the follow-up appointment?**

   A: At this time the clinician should complete the assessment with whatever information has been completed and include any potential diagnoses or rule out diagnoses.

6. **If the documentation of services and initial signature is completed within the 72 hour requirement, can the additional *required* signatures be outside of the 72 hours?**

   A: Yes, if the documentation of services requires additional signatures they may be obtained outside the 72 hour window.

7. **Does the 72 hour requirement apply to all provider types?**

   A: Yes, the 72 hour requirement applies to all Medicaid provider types unless the provider's professional licensing standards is longer.

8. **What is the definition of "professional licensing standards"?**

   A: For the purposes of 7 AAC 105.230, professional licensing standards under title 8 of Alaska Statutes (State of Alaska licensing standards) or any nationally recognized professional licensure; including but not limited to American Medical Association (AMA), American Dental Association (ADA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Counseling Association (ACA), Standards for Substance Abuse Counselors (SAMHSA), National Association of Social Workers (NASW), American Psychological Association (APA), American Speech-Language-Hearing Association (ASHA), American Occupational Therapy Association (AOTA), American Physical Therapy Association (APTA).

   Providers located out of state should comply with the licensing and documentation standards in their own state then fall back on any nationally recognized professional standard. If none of the above exist the 72 hour rule would apply.

9. **Hospital licensing standards allow 30 days for completing records. Would this standard apply to the providers who provide professional services within the hospital or would the providers' own licensing standards apply?**

A: There would be a distinction between a facility record, which would be subject to the 30 day rule in accordance with 7 AAC 12.770, and a provider. Physicians, Nurse Practitioners or Physician Assistants who provide in-patient hospital services, recorded in the hospital chart, but are billed as a professional-fee at fee-for-service rates, then the 72 hour or their own professional standards would apply, as applicable.

10. Does the 72 hour requirement apply to Care Coordination and/or Targeted Case Management Billing?

A: Documentation must be completed within 72 hours of the end of the date of service. For monthly services such as Targeted case management and Care coordination, the date of service is the last day of the month. However, dates for face to face and telephone contact must be documented in the record.

11. Does the 72 Hour requirement apply to Medicaid Administrative Claiming?

A: No, the 72 hour requirement only applies to services billed through the Medicaid Management Information System.

12. When is the new requirement effective? Is there a retroactive period? Is there any way that the implementation date can be pushed back 3-6 months to allow providers time to learn what is expected and adapt their systems?

A: The effective date of the regulation is dates of service June 7, 2018 and forward.

13. How does it work if the notes are not in to the database within 72 hours?

A: In accordance with the regulations, services must be documented within 72 hours of the end of the date of service. If the documentation of the service occurs outside of the 72 hour window, the provider should not submit a bill to the department for the service. If a claim is submitted for which the documentation was not completed within the 72 hours, it would be considered an overpayment for audit or self-audit purposes.

There is no requirement that the documentation be in an electronic format, you may use paper as a back-up, kept in accordance with 7 AAC 105.230.

14. Does this regulation package require the use of electronic recordkeeping?

A: The regulations allow for the use of electronic records but do not require it.

15. Are certain programs being allowed an exemption from this regulation?

A: This regulation is for all services being billed through Alaska Medicaid claims processing system including Chronic and Acute Medical Assistance (CAMA) program.

16. **Does the new regulation mean a provider has to bill for the service within 72 hours of performing the service?**

    A: No, in accordance with 7 AAC 145.005(c) A provider has 12 months after the date of service to submit a claim for payment. The new requirement is for documenting the service provided.

17. **Can the note just be "start" for or must it be fully finished to meet the 72 hour requirement or can it simply be a start like "saw client today"?**

    A: No, initial documentation must include enough documentation to support the service billed in accordance with 7 AAC 105.230.

18. **Our clinicians are often backlogged and keep short-hand summaries then catch up several weeks later, will the short-hand summaries count toward the 72 hour requirement?**

    A: Initial documentation must include enough documentation to support the service billed in accordance with 7 AAC 105.230.

19. **If our provider dictates notes immediately and then the completed transcription comes to the office once a week to be reviewed and signed, is this okay?**

    A: As long as the dictation occurs within 72 hours of the end date of service, dictation is considered initial documentation. The date of dictation and transcription should be documented.

20. **Our Therapeutic Foster parents write their notes daily, then bring them to the office once/week, then the notes are scanned into our EHR, is this okay?**

    A: Yes, initial documentation must include enough documentation to support the service billed in accordance with 7 AAC 105.230.

Self-Audit Questions

1. **The self-audit process referenced in 7 AAC 160.115 appears to address medical practices. I own a 12 bed ALH. Does this biennial requirement apply to me?**

   A: Yes, the self-audit requirement applies to all enrolled Alaska Medicaid providers.

   Additional information is available on the Medicaid Program Integrity web page at: http://dhss.alaska.gov/Commissioner/Pages/ProgramIntegrity/default.aspx

2. **When do I have to start doing the self-audit? Do I need to submit one now for 2016 & 2017 or is it after June 2018?**

   A: Alaska Medicaid providers are required to complete a self-audit once every two years. The first self-audit is due on or before June 7, 2020.

As an Example, a provider may choose to conduct a self-audit on calendar year 2018 claims, to account for timely filing, the provider must wait until the end of 2019 to begin the review. A sample of claims would be reviewed for compliance with regulations and due no later than June 7, 2020.

3. **An auditor of one of the programs discovered that the self-audit tool-kit link referenced in the regulations does not work. I'm referring to: CMS self-audit toolkit, Conducting a Self-Audit: A Guide for Physicians and Other Health Care Professionals, February 2016.**
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/audit-toolkit.html

   A: The CMS self-audit toolkit is uploaded on the Medicaid Program Integrity website under **Self-Audit Resources**: http://dhss.alaska.gov/Commissioner/Documents/medicaid/CMS-Self-Audit-Booklet-Feb-2016.pdf

4. **Do you know if there will be any training offered to providers or billing teams regarding the self-audits or any kind of breakdown of how those audits should be conducted, how frequently, or how many claims should be reviewed and over what date spans?**

   A: The Self Audit portion of your question is addressed in 7 AAC 160.115. You can find a copy of the new regulations here:
   https://aws.state.ak.us/OnlinePublicNotices/Notices/View.aspx?id=189946

   How a self-audit should be conducted:
   http://dhss.alaska.gov/Commissioner/Documents/medicaid/CMS-Self-Audit-Booklet-Feb-2016.pdf

   How frequently: Once every two years.

   How many claims should be reviewed: The sample size is determined by through a statistically valid random sample through RAT-STATS or other statistical software.
   https://oig.hhs.gov/compliance/rat-stats/index.asp

   What is the date span: Over one calendar year of paid claims.

Other Medicaid Program Integrity Resources:

Medicaid Program Integrity website

Provider Self-Audit Attestation form

Medicaid Program Integrity email address: **mailto:QAPIProgramIntegrity@alaska.gov**

7 AAC 105.230 Requirements for provider records:
(a) A provider shall maintain accurate financial, clinical, and other records necessary to support the services for which the provider requests payment. The provider shall ensure that the provider's staff,

billing agent, or other entity responsible for the maintenance of the provider's financial, clinical, and other records meets the requirements of this section.

(b) A provider's record must identify recipient information for each recipient including the

(1) name of the recipient receiving treatment;

(2) specific services provided;

(3) extent of each service provided;

(4) date on which each service was provided; and

(5) individual who provided each service.

(c) A provider's record must identify financial information for each recipient including

(1) the charge for each service provided;

(2) each payment source pursued;

(3) the date and amount of all debit and credit billing actions for each date of service provided; and

(4) the amounts billed and paid.

(d) A provider shall maintain a clinical record, including a record of therapeutic services, in accordance with professional standards applicable to the provider, for each recipient. The clinical record must include

(1) information that identifies the recipient's diagnosis;

(2) information that identifies the medical need for each service;

(3) identification of each service, prescription, supply, or plan of care prescribed by the provider;

(4) identification of prescription drugs dispensed in accordance with 7 AAC 120.100 - 7 AAC 120.140;

(5) stop and start times for time-based billing codes; and

(6) annotated case notes identifying each service or supply delivered; the case notes must be dated and either signed or initialed by the individual who provided each service; for electronic records, an electronic signature that complies with the requirements of AS 09.80 (Uniform Electronic Transactions Act) satisfies the signature requirement under this section; the individual whose name is on the electronic signature and the provider bear the responsibility for the authenticity of the information being attested to; and

(7) records that are maintained contemporaneously with the service provided; for purposes of this chapter, contemporaneous records are those records documented in accordance with the provider’s professional licensing standards, or within 72 hours from the end of the date of service, whichever is longer; a provider may not bill for services for which records were not kept contemporaneously.